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Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

**BRAND ORAL SR OPIOID
AGONISTS
PRIOR AUTHORIZATION REQUEST FORM**

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid #: _____

DOB: _____ City: _____
Month Day 4-Digit Year

PRESCRIBER INFORMATION

Prescribing Physician: _____ NPI: _____

City: _____ State: _____ Phone: _____

Fax: _____

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Physician's Signature

Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider ID#: _____

City: _____ State: _____ Phone: _____

Fax #: _____

DRUG/CLINICAL INFORMATION

Drug Name & Strength: _____ Quantity/Month: _____

Frequency: _____ Diagnosis: _____

Indicate asymmetrical dosing(if needed) ____am ____pm

List prior drug use:

1. _____ Length of therapy _____ days Reason for d/c _____

2. _____ Length of therapy _____ days Reason for d/c _____

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